BULLETIN

Founded 1872

Vol. 60, No. 3 Bulletin of The Mahoning County Medical Society March, 1990

Auxiliary member, Eleni Kasamias modeled the wedding dress from Attica, Greece. The dress was hand embroidered with a silk and velvet gold embroidered jacket. Wreaths of jewelry on the bride's forehead, gold chains and brooches on the dress are the traditional gifts from the groom and his relatives.

Auxiliary Hosts Bridal Fashion Show

For more photos and story see pages 18 and 19.

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BULLETIN

Mahoning County Medical Society
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The Bulletin is published nine times a year, monthly with the exception of May, July and August by the Mahoning County Medical Society, 5104 Market Street, Youngstown, Ohio 44512. Phone (216) 788-4700.

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Perspicuity

The public perceives a need for change in healthcare systems. Recent opinion polls indicate the public mood. Universal access to care is viewed as a right. Some form of National Health Insurance is viewed as a means of assuring this right to access. However people are unwilling to pay for such a system and do not believe that costs will be lowered or that the government should run the program.

The prevailing social patterns favor freedom of choice in medical care with first dollar coverage. There are very high expectations that the available technologies assure perfect outcomes.

There now exists a three-tiered system. At the top is the high option coverage with individuals who can afford deductibles. Next is the low option coverage of Medicare and Medicaid. At the bottom are the 30 million young and low income individuals with no coverage at all. Because of this stratification, there is simultaneously too much and too little care. The distribution of care needs to be re-oriented rather than pursue a planned scarcity which the government programs would foster.

Decisions need to be made by society as a whole, not just the politicians and special interest groups. There must be wise distribution of the limited dollars available. Increased access will result in increased cost. Consequently the patient as consumer of medical resources must be a participant in decision making.

Employer insurance coverage is now responsible for two-thirds of medical coverage. One strategy to make the patient a better "consumer" of medical resources would be to shift the responsibility back to the individual. Instead of health insurance being a tax free benefit, tax credits can be allowed for individual families to buy personal health insurance. There then exists an incentive for wise purchasing of the personally desired plan. The employee would no longer be bound by the corporate insurance decisions of the company but would have the individual opportunity to make a free choice. Those who could not afford the payments would be given vouchers by the government to purchase their own coverage.

This concept was aptly illustrated by a speaker at a recent medical meeting. He indicated that when checking into the hotel, he thought, "This place must cost an arm and a leg to stay at. But someone else is paying the bill so I might as well enjoy it." Under our current system, "someone else" is indeed paying the bill. Under programs such as Universal Health Insurance for Ohio, this same mind-set exists. This will encourage increased utilization and actually increase the costs. Any system in which the patient-consumer does not have a personal financial incentive to control access will be unsatisfactory in implementation.

Those systems that are government controlled, such as Canada, have built-in rationing schemes. This is accomplished by limiting access to new technology and limiting the availability of facilities. In 1988 Canada had 12 Magnetic Resonance Imaging units (one per 2,167,000 individuals) while in 1987 the U.S. had 900 units (one per 271,000 individuals). In the same time frame Canada had 31 Cardiac Catheterization units, while the U.S. had 1,234 units. Herein lies the decision that the American public must make. Do we reduce the cost of medical care by limiting technology and access to timely elective care?

We in the medical field can express our opinions and attempt to modify public perceptions, but ultimately the American patient will get that for which he is willing to pay.

James A. Lambert, MD

The following applications for membership were approved by Council.

Active:
Marc S. Ucchino DO

First Year in Practice:
Dannen D. Mannschreck MD

Non Resident
Servillano Y. Yumang MD

Information pertinent to the applicants should be sent to the Board of Censors.

The Medical Consumer

I used to be an avid fan of consumer rights. I still am but I am now seeing the other side of the coin. The phrase "a little bit of knowledge is a dangerous thing" comes to mind almost daily.

People now consider themselves "smart shoppers" and "informed consumers." After all, consumer magazines have been around for a long time. Until now I hadn't realized how this carries over to the medical field.

People are increasingly being asked to make medical decisions with minimal information. For example the most absorbant diaper is the best. A drug which was prescription but now can be bought over the counter is more effective. Take this pill or drink and loose weight fast.

The media is bombarding the public with tidbits of medical knowledge, enticing them to make a "Healthy Decision." The public, armed with this information or should I say misinformation is only too happy to make their choice. Who wouldn't choose a health care plan for maximum benefits at minimum cost. Unfortunately, the hidden cost is soon to be found.

To debate some of the issues seems pointless. Does it matter how much liquid a diaper can hold if you change it within a reasonable amount of time? If a medicine is effective in a certain prescription dose, why is it sold over the counter at a lesser dose? Isn't the best diet a safe diet?

Other issues however are worth nothing. The physician is often left to explain to the public the "hidden cost." When an insurance company rejects medical payment it is often the physician who is more accessible for explanations and complaints. It is difficult to tell a patient that they must have a procedure that is unlikely to be covered by their insurance plan. There are untold numbers of anecdotes in which a procedure was delayed only to have a potentially avoidable illness develop. We are all familiar with the patient who calls in with a self-diagnosed sinusitis or gastritis requesting Augmentin or Zantac. No need to be seen, we're told. They've had this before and besides they can't take off from work. A quick look at the chart shows they've not been in for a year. Just call in the prescription and that's that. Right?

Although physicians don't make the rules we are caught up in the consumer game. By nature of our profession we are easy targets to bail out the consumers who are stuck in the system. No charge for this office visit; write-off that lab fee; treat over the phone to save an office visit. We do it all the time for medically appropriate reasons and I am by no means suggesting this is wrong. Patients need to become accountable for choices they've made. As an advocate for my patients I am glad to help them in all their medical decisions, explaining the diagnosis, procedures, labs, prognosis and even charges and insurance. With this approach I hope the patient becomes a wiser consumer of medical goods, and realizes physicians can be a proponent of patient rights and just may have some better information than television or magazines. □

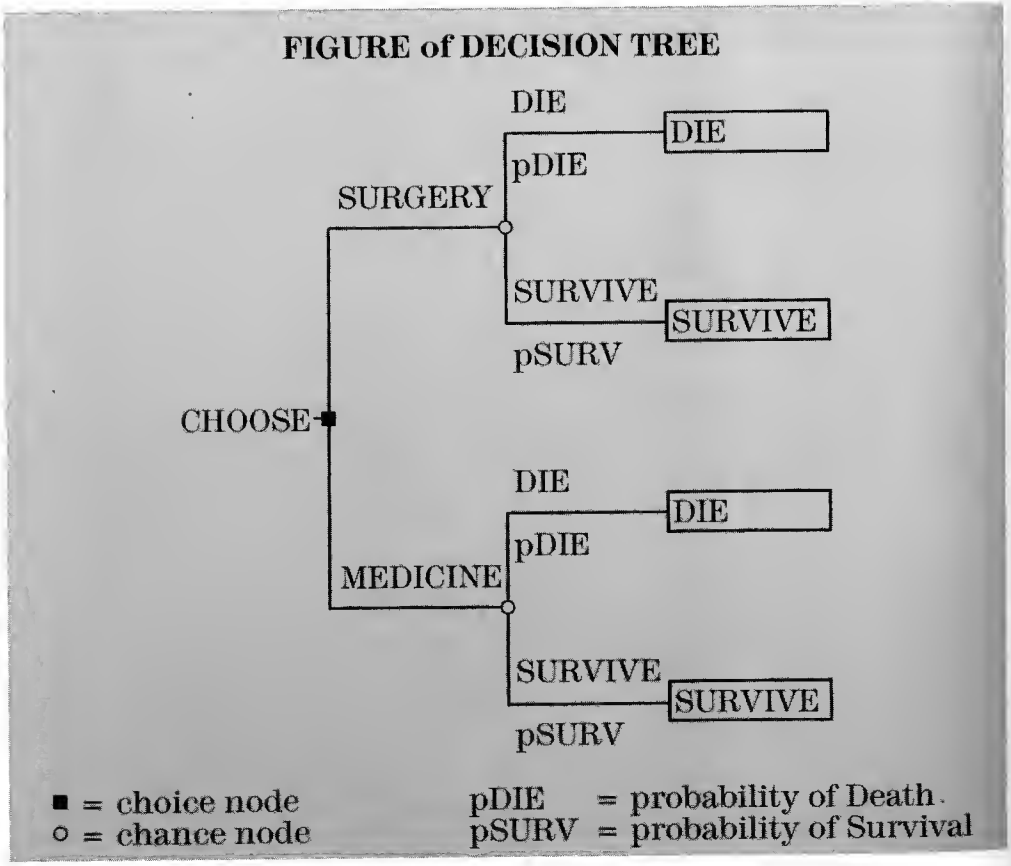
Denise L. Bobovnyik, MD

The Decision Tree

The complex tasks of clinical reasoning may be modeled using either the algorithmic or Bayesian approach. Algorithms provide branching flow charts which incorporate step by step pathways of instruction, based upon well defined rules, grounded upon past experience. They instruct the clinician "WHAT" to do under specific clinical situations. However, the "HOW" and "WHY" are rarely explored! Alternative choices and their respective outcomes are neither compared nor evaluated.

The decision tree is a problem modeling approach foreign to many physicians. In one sense the decision tree creates no new data, but it does provide a structure for optimizing existing information. The clinical problem is presented as a quantitative algorithm which incorporates the temporal sequence of events and their probabilistic nature. Tree structuring is thus a process of dividing the problem into smaller subunits to which appropriate component probabilities may be assigned. Clinical experience guides the construction as it does the algorithmic model. However this insight will be of little predictive value without the exactitude provided by Bayesian probability and mathematical quantitation. This later process provides an analysis of the frequency of events among alternative choices as well as a comparative value for the outcomes resulting from such choices. The structure of a clinical decision tree contains 4 basic elements simply categorized as 1) a clinical starting point 2) choices 3) probabilistic events and 4) outcomes. Choices are represented as squares while chance nodes are represented as small circles. (see Figure) The structure of the tree itself represents both temporal and

FIGURE of DECISION TREE



Leonard P. Caccamo, MD, FACP

Kimbroe Carter, MD

The Decision Tree (Continued)

logical considerations of the problem where the particular sequence of actions and events flow from left to right. The outcomes found at the right or terminus of the tree are called leaves and their values inclosed in a rectangular box. The pathway is thus analogous to the map of a river flowing from left to right, from its upstream source or starting point to its downstream delta endpoints where the river joins the sea. In order to predict the best overall strategy at the starting point, the subunits are mathematically calculated in a reverse process called "foldback" which begins downstream and works backward to the start point. The details of this operation will be illustrated later using a meaningful example. In summary, the physician selects the best strategy for the patient based upon the choice yielding the greatest numerical value for the patient. In part this approach goes a long way toward removing the complications of personal, social or environmental bias from the process of choosing a solution for the clinical problem. Decision trees will not avoid all misadventures, however they do minimize such misfortunes while highlighting and valuing alternative choices.

Structuring a clinical problem obviously requires well defined START and ENDPOINTS which will be guided by the viewpoints of those for whom the analysis is being performed, either an individual patient or perhaps a group of patients for whom policy is being determined. Regardless of viewpoint the unwary often confuse choices with chance events. There is a choice in acquiring more information, however, the result obtained represents a chance event. Different therapeutic interventions represent choices the physician may make while the results of such choices are subject to chance occurrences. Health outcomes may be such occurrences as death, compounding disease, degress of disability, discomfort, dissatisfaction or some measure of privation. In summary the decision tree combines the temporal and logical sequences of events between the starting point and the final outcome!

Next month we shall present a specific clinical problem, and construct a tree.□

"Health Access America" Announced

Recently the American Medical Association announced the *Health Access America* proposal designed to extend health care coverage to America's estimated 31 million uninsured.

In developing the specific provisions of the proposal, the AMA considered the following principals:

- **Strength.** Improvements to the American health care system should preserve the strengths of our current system.
- **Access.** Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
- **Security.** Particular efforts are needed to assure continued access by the elderly to affordable health care services.
- **Affordability.** Health care services should be delivered with high quality at appropriate costs.
- **Freedom.** Patients should be free to determine from whom and the manner in which health care benefits are delivered.
- **Quality.** All physicians should be committed to the highest ethical standards in the delivery of care to patients.

The Health Access America 16 point proposal summarized below, is a blueprint for extending access, controlling inappropriate health care cost increases, and sustaining the Medicaid & Medicare programs to assure health care for all Americans. It was developed by the AMA primarily to emphasize the advantages of the American system and to offer solutions to the systems's problems in an attempt to avoid a national health insurance plan.

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.
2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.
3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.
7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high quality medical services are provided, lowering costs and maintaining quality of care.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
9. Develop proposals which encourage cost-conscious decisions by patients.
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk spreading groups and reinsurance.
11. Urge expanded federal support for medical education, research and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.
12. Encourage health promotion by both physicians and patients to promote healthier lifestyles and disease prevention.

"Health Access America" Announced (Continued)

13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.
14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.
16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

Workshop on Ohio Medicaid At-Risk Pregnancy Services May 17

A workshop on the At-Risk Pregnancy Services covered by the Ohio Medicaid program sponsored by the Mahoning County Medical Society, the Mahoning County Children Health Coalition and the Mahoning County Department of Human Services is scheduled for May 17. All physicians who provide pregnancy services to Medicaid patients are invited to attend or send staff for the workshop, to be conducted by Charles Zalac, Health Program Specialist of the Bureau of Medicaid Preventative Health, at First Presbyterian Church—Wick Avenue, Youngstown, from 9:30 a.m. until noon on Wednesday or Thursday, May 17.

Mr. Zalac will address eligibility for At-Risk Pregnancy Services, the range of services covered by the At-Risk Pregnancy program and related billing issues. The At-Risk pregnancy program is designed to identify pregnant women who are at risk of negative outcomes of pregnancy. The definition of At-Risk pregnancy is broad and a large percentage of Medicaid recipients are identified as At-Risk.

The At-Risk Pregnancy Program Medicaid pays for a number of services, such as counselling and education services, which are not otherwise reimbursable under Medicaid. The county department of human services assists with care coordination, including helping the woman get to scheduled office visits.

Other providers of services to At-Risk pregnant women, such as the WIC feeding program, drug and alcohol clinic, and health departments also will be present to explain the services they offer to At-Risk pregnant women.

To register for this free workshop please call the Society office (788-4700). For further information call Robert Ferrara at the Mahoning County Department of Human Services (740-2747) or the Society office.

Civilized Professions Don't Eat Their Young

In the Journal of American Medical Association, January 26, 1990—Vol 263, Page 533, I read with interest an article by Sheehan et al, entitled "A Pilot Study of Medical Student Abuse". The article was put together through a questionnaire in collaboration with the American Medical Association's Office of Education Research and was approved by the college's Research Committee on Students. It was administered to an entire third year medical school class in a special meeting in late Fall of 1988 with all students remaining anonymous. The students were asked to rate the frequency and cite sources of mistreatment and misconduct among classmates, faculty, residents and interns. They were also asked to assess the effects of such episodes on their physical health, emotional well-being, social and family life, and attitude toward becoming a physician. Results of the study indicated that students perceived mistreatment (particularly verbal abuse and unfair tactics) to be pervasive and professional misconduct all too common. As many as three fourths of the students reported having become extremely cynical with academic life in the medical profession as a result of these episodes. Two thirds of the students felt that they were worse off than their peers in other professions. More than one third considered dropping out of medical school and one fourth reported that they would have chosen a different profession had they known in advance about the extent of the mistreatment that they would experience.

While this episode and study dealt with medical students, one wonders what the results might be if a similar study were carried out with medical residents. The first paragraph from the Oath of Hippocrates states, and I quote, "I do solemnly swear by whatever I hold most sacred that I will be loyal to the profession of medicine and just and generous to its members." We all have significant needs for affirmation and the need to form our ideals which begins in our youth and persists into our adulthood. Providing affirmation and depicting a good role model are traits that every physician should possess. If indeed the profession of medicine is to continue, setting high standards should be the motivating force for any teaching hospital or university medical school. As it was pointed out in the JAMA editorial, just as the needs for idealization and for affirmation are essential to develop a cohesive sense of self in the child and well-being of the adult these needs are also especially critical in a student/teacher relationship.

Students, residents and junior faculty seek inspiration from their teachers as they attempt to find their own direction and areas of particular interest within medicine. I recently had the opportunity to sit with the Year V class as they discussed with the Year VI class the process of deciding upon a future residency and how one applies for those positions. It was apparent to me as they discussed their goals and their future that community hospitals have a major challenge in competition with the university facilities. The university hospitals provide the opportunity, particularly for a primary care physician, to understand the caring and compassion that is required by all patients. If students and residents can look up to their teachers, find them enthusiastic, dedicated and caring about their patients and students, these students and residents would experience an exhilarating idealism for creating enthusiasm in themselves. This obviously would then sustain them during the hardships of their professional career and might well endure for the rest of their professional lives. In the absence of such enthusiasm, dedication and caring on the part of their teachers and professional peers, students and residents will very likely become less effective physicians.

If you have not had an opportunity to pick up the book "House of God", you have missed an important part of what our house staff and medical students see in contemporary medicine. Although the 13 laws of the "House of God" were constructed in poking fun toward the life style of a busy resident, they may

Gene A. Butcher MD

well cause concern for future professionalism. Law students, for example, traditionally are portrayed in films and novels as being educated in a rather confrontative and often callous fashion. Is the "House of God" any less abusive than "The Paper Chase"? At a time when a number of qualified applicants to medical school has either been in a decline or in a plateau mode, experts are voicing concern about stress, harassment, unfavorable working conditions and the need for critical change in medical education. The problem of medical student and resident mistreatment certainly deserves special attention by the whole profession.

It is easy to dismiss these issues as isolated events or the perception of disgruntled, naive and emotionally insecure students and residents. One may also rationalize that these experiences are confined to a particular stressful period in medical school and subsequently in their residency role. Hopefully as students and residents gain experience, their outlook will become more positive and hopeful. In the context of continued declines in qualified medical school applicants, increases in physician workloads and limits on fees, a less favorable view of the physician by society, a growing perception that medical education is unenjoyable, and mounting concern about emotionally ill health, declining humanitarianism, dishonesty, greed, cynicism and lack of independent thinking, it is important that we very closely concern ourselves with medical students and residents' perceptions of mistreatment and misconduct. If we are anxious to attract well adjusted and talented young people into the profession of medicine, we can ill afford to have an environment that is perceived by some to be adversive, hostile or abusive. On the contrary, we should do what we can to make the environment of medical school and residencies as attractive, appealing, encouraging and educational as possible.

Youngstown Country Club was the setting for the Auxiliary Guest Day International Bridal Fashion Show Luncheon held on Thursday, March 22. A magnificent array of wedding attire from women for the countries of China, Greece, Korea, India, Iran, the Philippines, Spain, Sweden and the United States was featured.

Rosemary Memo, commentator, noted that the bridal gown which has traditionally been richly colored has, in each culture, been passed down from generation to generation. In the Middle Ages, red was the favored color and still is in the Hindu, Islamic and Chinese cultures. Iceland has, for the past 50 years, used black velvet trimmed with gold and silver. White has been used more recently.

Auxiliary members acted as models. *Anita Gestosani* wore a empire style gown from Czechoslovakia. The gown, which was 55 years old, belonged to *Marsha Turocy's* grandmother. It was antique satin, trimmed in antique Belgium lace. The cathedral length veil of 23 feet was attached to a camelot style headpiece.

The Swedish gown, worn by *Mary Walton,* consisted of a black wool skirt, vest and a white blouse. The design on the striped apron designates the province from which the bride came.

Suzie Soloeimani wore the gown from the tribe of Kurds in Iraq. The gown was pink, black and gold with sequins. Solid gold chains containing precious stones were worn around the neck. It is the custom for the bride to wear many gowns throughout her wedding day, depending on the gifts of clothing given by the groom's relatives.

The Moslem wedding dress from India was worn by *Rehana Fatteh.* Gold sequins covered the brightly colored gown. Henna was placed on the hands and feet in a design for good luck.

The Hindu wedding gown from India was worn by *Deval Lakhani,* daughter of Dr. & Mrs. Prabhudas Kakhani. The sari was brightly colored with gold sparkles throughout the gown. Black beaded gold chains are worn to signify marriage. The symbol of a married woman in the Hindu tradition is a red dot, called a Binde, on the head.

The Chinese gown was worn by *Florence Wang.* The gown consisted of a red silk skirt and a jacket with a mandarin collar. Red is the symbol of good luck and happiness. The headdress, with pearls & diamonds, covered the entire head. Designs of dragons on the headpiece symbolizes the groom and the Phoenix, on the headpiece symbolizes the bride.

Cara Lee wore the traditional three piece Korean gown. The Geogori is the top piece, the Chima is the bottom flared skirt and the Wonsam is the long overcoat. Silk fabric is used for winter and organza for summer. The tiara (or Jokdure) consists of jade, pearls, coral, semi-precious stones and golden thread.

Marie Latorre was chairman and *Ann Buckley* co-chairman of this successful event which raised $1,300.00 for the Battered Persons' Crisis Center. Committee members included: *Beth Bacani, Linda Evans, Anita Gestosani, Dolly Handel, Pauline Sarantopoulos, Suzie Soleimani, Mary Walton* and *Florence Wang.*

Anita Gestosani — Gown from Czechoslovakia

At A Glance

Photos courtesy Mary Jane Jenkins

Florence Wang — China

Mary Walton — Sweden

Cara Lee — Korea

Deval Lakhani — Hindu gown from India

Suzie Soleimani — Iraq

Rehana Fatteh — Moslem gown from India

Medical Assistants Hold Election

Stephanie Pizzuto has been re-elected president of the Mahoning County Medical Assistants.

Other officers are: Nena LaBarbera, president-elect; Betty Ann Perschka, vice president; June Kyle, recording secretary; Mary Ann Rushton, corresponding secretary; Dee Davis, treasurer; and Nancy Donahue, Kathylynn Feld, and Jean Backman, councilors.

Representing the group at the 33rd Convention of the AAMA, Ohio State Society of Medical Assistants will be Stephanie Pizzuto as delegate and June Kyle as alternate delegate. The convention will be held April 26-29 at the New Market Hilton Hotel, Canton. □

In Memoriam
Frank W. Morrison MD
1920-1990

On February 17, 1990 the soul of Frank W. Morrison left this earth and undoubtedly entered the Kingdom of God.

We admired and loved him for that steadfastness and strength. We shall miss him as well might all of us.

Donna, his wife, lost a good husband. His seven children lost a fine father. His three brothers lost a member of their quartet. His patients lost a good doctor who exemplified the best in doctor-patient relationship—something so much sought for by everyone yet found by too few. The hospital lost a fine staff member who was quietly, intensely, and loyally interested in maintaining the hospital as the best sanctuary for the seriously ill. The Lions' Club and the community at large lost a socially dedicated and charitable citizen. The nation lost a battle-proven, decorated veteran. The Catholic Church lost a staunch, basically-sound member here on earth, but gained a loyal advocate in heaven. And I, with my wife, lost a good, good friend.

It would be grossly presumptuous on our part to convey the concept that we were Frank's only friends or that those friends were few in number. Nothing could be further from the truth; for, in fact, he was wealthy in friendship and friends. They covered the whole social spectrum-including people of both sexes, all races, all classes economically speaking, all ages, and all religions.

My wife and I have tried hard to find a common and appealing denomination as a basis for this general appeal. We believe we found at least one in the fact that he was a joyfully principled person. He firmly believed in and practiced those basic values that have stood mankind in good stead over the centuries. He found contentment within them and did not seek acceptance in any area where these were compromised.

C. Edward Pichette MD

Medicare Regulations on Waiver of Coinsurance and Deductible Amounts

If a Medicare audit reveals that you routinely and consistently waive patients' coinsurance and deductible amounts without making reasonable collection efforts, you could be in violation of the Social Security Act pertaining to false claims and kickbacks. Violations could result in reductions of your allowable charges based on actual charges expected to be received, or referrals to the Office of the Inspector General, Department of Health and Human Services, for suspension or exclusion from the Medicare program.

Unallowable Waivers. The following examples indicate a physician/supplier reduces his actual charges:

1. Ads stating coinsurance/deductible will be waived.
2. Unsolicited advice to nonindigent patients that coinsurance/deductibles will be waived.
3. Higher charges to Medicare patients (to offset "waiver").
4. Waiver of coinsurance/deductibles to a specific group of Medicare patients, e.g., referrals from a particular hospital.
5. Waivers for the majority of Medicare patients for any reason other than disproportionate billing costs, i.e., billing costs exceed amounts to be collected.

Allowable Waivers. The following examples do not constitute reductions of actual charges:

1. Provider may waive coinsurance/deductibles based on determination of a particular patient's indigency. (Notify the patient that he need not pay coinsurance/deductibles and document the patient's file as to the circumstances related to waiver.)
2. Billing costs exceed amounts to be collected.

Providers who waive coinsurance/deductibles for the majority of Medicare patients and/or make no reasonable attempt to collect coinsurance/deductibles may be in violation of Medicare law and subject to applicable penalties.

A New Look at Lead Poisoning

The known adverse health effects of lead exposure in infancy and early childhood continue to grow in number as investigators examine the effects of low level lead exposure on growth and development. Because lead crosses the placental barrier, posing a potential risk to the unborn child, recent studies have focused on prenatal lead exposure and have provided consistent evidence of subtle developmental impairments at maternal blood lead levels well below the current Centers for Disease Control 25 mcg/dl definition of lead toxicity.

In a prospective study of middle class Boston children, performance on standardized tests of infant development was poorer for children born to mothers with umbilical cord blood lead levels greater than 10 mcg/dl.

These effects were observed in another prospective study of prenatal exposure in a group of Cincinnati infants. In addition, reductions in gestational age and birth weight associated with fetal exposure levels of greater than 15 mcg/dl were observed. For every 10 mcg/dl increase in maternal blood lead levels there was a corresponding one-half week decrease in gestational age at birth. Reductions in birth weight ranged from 58-601 grams depending on maternal age.

From these reports it is possible to make a strong case for identifying fetuses as a high risk group for lead toxicity and to conclude that fetal exposure at maternal blood lead concentrations of 10-15 mcg/dl constitutes a level of public health concern.

Although there are multiple sources of lead exposure in the environment of the pregnant woman, uptake of particulate lead in dust and paint account for a large share of her body burden of lead. A woman's threat of exposure to lead-containing dust and paint is largely determined by the age and condition of her home, although occupational exposures are occasionally implicated. In assessing risk of lead exposure from housing, the Agency for Toxic Substances and Disease Registry divided housing units into groups by age. Housing constructed before 1950 has the highest concentration of lead in paint. Although there are no estimates of the number of pre-1950 housing units in which pregnant women or women of childbearing age reside, available data on numbers of infants and young children living in such housing provide a useful approximation. In the Youngstown-Warren Standard Metropolitan Statistical Area (SMSA) which includes Mahoning County, over 40% of children ages six months to five years, or approximately 18,000 children, live in pre-1950 housing, placing Youngstown-Warren in fifty-first place nationwide among SMSAs in numbers of children—and parous women—potentially exposed to lead containing paint and dust.

Methods for the abatement and control of home lead paint and dust hazards are uniformly complex and labor intensive. Constrained by a lack of public funds committed to primary prevention of lead toxicity through complete removal of lead paint from homes, the public health community continues to seek low-cost, practical strategies for control of home lead exposure until an outright ban on lead in the home becomes feasible.

Recognizing that the adverse effects of prenatal exposure may attenuate over the first few years of life if postnatal exposure is prevented through early detection and control of lead sources, the Mahoning County and Youngstown Health Departments, with support from the Ohio Department of Health, have undertaken Ohio's first primary prevention program for childhood lead poisoning through screening of women enrolled in Mahoning County Child and Family Health Services prenatal clinics. This program is designed to evaluate the effectiveness of lead hazard detection methods in prenatal patients' homes and subsequent intervention to control lead sources using cleanup methods, short of total abatement, that significantly reduce dust lead levels at negligible cost.

The intervention will be considered a cost-effective preventive measure if follow-up home monitoring shows that

Matthew A. Stefanak, M.P.H.
Health Commissioner

particulate lead levels are reduced and remain low and if infants born to women living in homes selected for intervention are at no greater risk for elevated blood levels than infants born to women living in lead-free homes. Our results to date reveal an 8-10% prevalence of maternal blood lead elevation above 10 mcg/dl in the prenatal clinic population. □

Bellinger D. et al. Longitudinal analyses of prenatal and postnatal lead exposure and early eognitive development. *NEJM* 1987a;316:1037-42.

Dietrieh K. Kefafft K, Bier M, Bornsehein R, Naraine S, Suerop P. Low-level fetal lead exposure effeet on neurobehavioral development in early infancy. *Pediatrics* 1987b;80:721-30.

50 Years Ago - March 1940

J. B. Kupec was in the hospital with pneumonia. Everybody else had the "flu". R. V. Clifford was at Johns Hopkins in Baltimore studying surgery and pathology. Clarence Stefanski was running for coroner on the Republican ticket. This was a Republican town in those days so he had no trouble getting elected.

Council decided that Youngstown should have a full time Director of Health, and that he should be a physician. New members were Vernon L. Goodwin and Erhard Weltman.

40 Years Ago - March 1950

President Nelson took the membership to task because, in the last election, 10% of them did not even register. New members that month were Fred Schlecht and F. A. Resch.

30 Years Ago - March 1960

C. W. Stertzbach urged the members to study the Forand Bill, another scheme to obtain government control of the medical profession. Doctors were already concerned about the Aid for the Aged program which had a payment program which nobody understood. (Sound familiar?) Ben C. Berg was doing a tour of duty in the Philadelphia Naval Hospital. W. P. Young was appointed to the Board of Trustees of Wilberforce College.

New members that month were: James Fulks, David R. Ginder, Rene Cossette, S. K. Haller and Engelburt Hecker.

20 Years Ago - March 1970

Father Daniel Egan, the "Junkie Priest", spoke to the Women's Auxiliary on the problem of drug abuse, and also spoke at Rayen School. He appeared on Dan Ryan's "Open Mike" program, and made two tapes for Television. He urged that the abandoned T. B. Sanitorium be converted to a Halfway house and treatment center for those who had a drug addiction problem.

The Future Physicians Club at St. Elizabeth Hospital made a trip to the Narcotics Hospital at Lexington, Ohio, and the Youngstown Health Dept. announced a new program on "Early Drug Education" in the City Schools.

New active member that month was Dr. Bernard Schneider. New Associate Members were: Drs. Paul and Marie Krupko and Dr. Michael E. Sheridan. Intern-Resident member was Dr. Joseph S. Gregori.

10 Years Ago - March 1980

Editor Richard Murray wrote a scathing denouncement of the Joint Commission on Accreditation of Hospitals, describing it as a Committee that has gotten too powerful and autocratic, and called for its dismantling.

St. Elizabeth Hospital Medical Center announced plans for opening a new, more modern and enlarged Emergency Department, and called for suggestions from the members regarding what resources and facilities they would like to see incorporated into such a department.

Dr. Clare Reesey was named Director of the Family Practice Center and Associate Director of the Family Practice Residency Program at Youngstown Hospital. Dr. Jacque Politi was elected to Diplomate of the American Board of Allergy and Immunology, and Dr. Ludwig Deppisch was appointed course director of general pathology at NEOUCOM.

New members that month were, Active: Dr. Kong T. Oh, Associate: Dr. Antonio T. Gestossin, Dr. John Politis and Dr. Kolli M. Prasad. □

Robert R. Fisher, MD

Primary Care Preceptorship Program— A Valuable and Rewarding Learning Experience

One of the best ways to teach medical students about primary care medicine is to provide them with an opportunity to work with physicians in primary care settings.

That opportunity exists for students from the Northeastern Ohio Universities College of Medicine (NEOUCOM) through the Primary Care Preceptorship program, of which I have been a part since its inception.

Now in its fifth year, the program is viewed by NEOUCOM students and practicing physicians as a valuable and rewarding learning experience.

All junior medical students at NEOUCOM are required to take the four-week community preceptorship. During this time, they are assigned to a primary medical practice where they participate directly in clinical and community health activities, examining and treating patients under the supervision of a precepting physician who serves as a positive role model.

During a typical preceptorship experience, the student accompanies the physician in all professional duties, including hospital and nursing home rounds, weekend calls, and meetings relating to the profession. Office hours are spent observing and assisting in the resolution of patient problems learning about practice management (ie: appointment scheduling, records management, billing, insurance systems, etc.), and researching selected topics relating to community and individual health problems.

Ultimately, early exposure to communities and practicing physicians will prepare students for eventual practice realities and help them focus their future career choice.

C. William Keck, M.D., M.P.H., Director, Division of Community Health Sciences, said, "It's important for students to have primary care practitioners as role models and to see primary care as a viable career option. Even for those students who are not oriented toward primary care, as specialists they will be receiving referrals from physicians in primary care."

The preceptorship program is supported by over 150 family medicine, internal medicine, and pediatric practitioners in 20 northeastern Ohio and one western Pennsylvania county. Between 90 and 100 medical students annually are placed with practicing physician preceptors. Since the selective's inception in July, 1985, 370 students have completed the experience.

Benefits for the physician include:
• Having a student around as a way to keep in touch with current ideas and get an infusion of new thoughts while sharpening the teaching of skills used every day when dealing with patients.
• Helping keep ties with the medical school with educational and contact benefits flowing in both directions.

There are also benefits for the patient. Most of them welcome the student and the extra time and attention given to them.

Students' comments about the program are also extremely positive. "I feel more confident about my decision to enter primary care..." "This was a superb experience. I learned so much about interpersonal interactions - things that can never be taught - only experienced..." "It made me realize that primary care is a very satisfying and exciting career choice..."

Personally, the experience has been extremely enjoyable and I have found the contribution to the students' growth as future physicians to be extremely rewarding.

If you would like to learn more about the Primary Care Preceptorship program, call Joyce Bender, Division of Community Health Sciences, NEOUCOM, 747-2247, ext. 592, or Patricia Mascolo, Dept. of Family Medicine, NEOUCOM, 379-5888.

Emil S. Dickstein, MD
Associate Professor of Internal Medicine
Northeastern Ohio Universities College of Medicine

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